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COVID-19 pandemic impact on the therapeutic setting in Mental Health Services

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Abstract. *Background:* The new 2019 coronavirus disease (COVID-19) outbreak forced mental health providers to overcome their general reluctance about telematic assistance, shifting from a face-to-face approach to online therapy to promote continuity of care for psychiatric patients. *Methods:* An ad-hoc web-based survey questionnaire assessing the impact of the COVID-19 pandemic on therapeutic setting in Mental Health Services was sent via email from March 15, 2021 to June 15, 2021 to mental health providers in Genova, Italy. The survey was anonymous and a free Google Forms® software was used. *Results:* Two hundred nineteen mental health providers completed the survey, and the overall response rate (ORR) was 65%. During the COVID-19 pandemic period, the continuity of care was mainly guaranteed using electronic devices. Psychologists reported a higher availability of video call assistance service to guarantee continuity of care for psychiatric patients compared to psychiatrists and psychotherapists (p<0,001). Psychiatrists reported the lowest degree of satisfaction about this new telematic approach (p<0,01), while psychologists and to a lesser extent psychotherapists speculated to use it even in non-pandemic times (p=0,02). *Conclusions:* COVID-19 pandemic creates an opportunity to overcome normative, technological and cultural barriers to the use of online psychotherapy, showing the importance of adapting the therapeutic setting to both collective and individual needs. Despite initial concerns about its effectiveness and efficacy, a general degree of satisfaction was expressed by the majority of the mental health providers. Further efforts will be needed to enhance this new way of working and to train therapists with particular regard to those employed in the public health system. (www.actabiomedica.it)

Key words: COVID-19, mental health, therapeutic setting, psychiatrist, psychologist, psychotherapist

Introduction

The new 2019 coronavirus disease (COVID-19) outbreak forced mental health providers to overcome their general reluctance about telematic assistance (1), shifting from a face-to-face approach to online therapy to promote continuity of care for psychiatric patients (2, 3).

Although ensuring continuity of care via teleconsultation might lower the risk of clinical decompensation and consequent need of hospitalization for those patients (4), either ethical or privacy issues, as well as concerns about effectiveness of online psychotherapies have been expressed by specialists of every theoretical orientation (5). Further concerns emerged in case of a

psychoanalytic approach, as far as the online therapy could be seen as a violation of the therapeutic process and of the analytical structure (6,7).

Beyond the minimum rules allowing a therapeutic alliance between patient and therapist (organizational dimension of spaces, costs, times, models), the therapeutic setting can be considered as an instrument in which a mental space for listening and holding the verbal and extra-verbal communications of the patient is edified. In this framework, setting can be depicted as a meeting place, in which therapist and patient move following the encoded "rules of the game".

Considering the setting as a dynamic process, it can be modified based on patient's specific needs. However, setting variations can occur regardless patient's needs. Liberman suggested that setting is made of uncontrollable elements which can be considered the inevitable expression of our location in a reality framework. The author attributes these elements to the "meta-setting", intended as the "social, cultural and economic environment surrounding us" (8).

COVID-19 pandemic exposed us to a shared trauma (9), producing effects on both therapists and patients, and determined the co-creation of a different way of "staying together" in the virtual room of therapy. Trauma can be considered as a fracture in the stability and continuity of the therapeutic experience. Such a fracture, regardless the types of interventions, the therapist's age and clinical experience and the target of care, required a variation in the therapeutic work at several levels of the setting (10,11). Paradoxically, only through the enrichment of the setting of elements coming from the reality framework, it's possible to keep the treatment process alive and to preserve the possibility of satisfying the request for help (12).

Since the World Health Organization declared the COVID-19 outbreak a pandemic, several countries promoted telehealth services, including online psychotherapies. In line with that, aim of our study was to understand how the change of the therapeutic setting has been perceived by mental health providers depending on their position, on the patient's diagnosis, on the therapeutic target, and on the availability of electronic devices.

Methods

Sample

As done before (13,14), an ad-hoc web-based survey questionnaire (see Appendix) preliminarily exploring the impact of the COVID-19 pandemic on therapeutic setting in Mental Health Services was sent via email from March 15, 2021 to June 15, 2021, to mental health care unit directors and deans of psychotherapy schools in Genova, Italy.

The survey was on voluntary based, anonymous, and confidentiality was ensured. Written consent was given to all individuals before participating in the questionnaire/study. Participants were allowed to terminate the survey at any time they desired, and no monetary rewards were given for completing the questionnaire. A free Google Forms® software was used.

Survey questionnaire

The 17-items survey was a non-validated instrument, as conceptualized for emergency purpose, made by mental health providers with different theoretical approaches involved in both public and private healthcare system.

The first section of the questionnaire investigated the position of mental health providers (psychiatrists, psychologists, psychotherapists), the place of work, the accessibility to a video call system and the acceptance for both patients and operators of a change of the setting conditions.

The second section of the questionnaire investigated how the change of the clinical setting was perceived by therapists, as far as it concerned their competences and way of working, and how patients answered to this change.

The third and last section of the questionnaire investigated the clinical and practical benefit and difficulties faced by operators in the shift from a face-to-face to a video call approach.

Statistical Analysis

Clinical data were presented as means ± standard deviations (SD) or counts and percentages for con-

tinuous and categorical variables, respectively. Instead, to identify differences in mental health providers selected, the Mann-Whitney non-parametric tests were used. ANOVA and Fisher Chi squared were employed for statistical comparisons. All the analyses were performed using the Statistical Package for Social Sciences version 25.0 (SPSS Inc., Chicago, IL, USA) with a statistical significance threshold of $p < 0.05$ (two-tailed).

Results

Two hundred nineteen mental health providers completed the survey, and the overall response rate (ORR) was 65%. No questionnaire was returned incomplete. The current mean age of the total sample was 47.5 ± 9.5 years and one hundred twenty-five (57.0%) responders were females. Based on the type of assistance, three subgroups were identified: psychiatrists (N=66), psychologists (N=104), and psychotherapists (N=49). Psychologists were mostly represented by graduate attending a psychotherapy school.

Around 35% of participants worked in the public National Health System, 40.6% in the private healthcare sector, while 23.7% both in public and private sectors. Compared to psychiatrists (33.3%) and psychotherapists (24.5%), the majority of the psychologists worked in the private sector (52.9%; p<0.001).

Compared to psychiatrists and psychotherapists, psychologists reported a higher availability of video call assistance service to guarantee continuity of care for psychiatric patients (92,3% of psychologists *vs.* 54.5% of psychiatrists and 69.4% of psychotherapists, respectively; p<0.001). Even the start of a new therapeutic relationship exclusively in video-dial mainly involved psychologists and psychotherapists compared to psychiatrists (57.7% and 51.0% *vs.* 24.2%, respectively; p<0.01).

Psychiatrists reported the lowest degree of satisfaction about this new video-assistant approach (42.4% *vs.* 65.3% of psychotherapists and 74% of psychologists, respectively; p<0.01), while psychologists and to a lesser extent psychotherapists speculated to use it even in non-pandemic times (45.2% and 36.7% *vs.* 28.8% of psychiatrists, respectively; p=0.02).

Moreover, compared to psychotherapists and psychologists, psychiatrists reported a higher tendency of patients to contact them outside working hours (2.6 ± 1.2 *vs.* 2.0 ± 1.1 and 1.8 ± 1.1, respectively; p<0.01) and to ask for reassurance about the pandemic (63.3% *vs.* 36.7% and 26.0%, respectively; p=0.01).

When asked about the perceived feelings of their patients about the change of the therapeutic setting, 57% of the mental health providers, mostly psychologists, reported that patients seemed to appreciate it, despite the physical absence of the therapists, because of a feeling of acceptance and consolation deriving from the relationship in a period of social distancing. On the contrary, 43.9% of the mental health providers noticed a strong wish to turn back to the previous condition in their patients, and 42.5% reported how some patients perceived a less close and reserved relationship with the therapist, especially when they did not have a good housing environment.

When asked about their own feelings about the change of the therapeutic setting condition, the majority of the participants (61.5%) was reassured by the possibility of continuing the therapeutic relationship, while 42.1% of the mental health providers benefitted from feeling socially useful at a collectively level.

Moreover, meeting the patients in their everyday life helped to better understand the interior world by 21.7% of the participants, especially for psychotherapists (12.2% *vs.* 4.5% of psychiatrists and 1.9% of psychologists; p= 0.024). Negative feelings included: difficulty in communication when patients were only contacted by phone (29.9%); difficulty in concentration, especially reported by psychotherapists (42.9% *vs.* 25.8% of psychiatrists and 18.3% of psychologists; p= 0.005), the fear of an insufficient clinical control, especially for psychiatrists (43.9% *vs.* 30.6% and 24.0%; p=0.024).

Other findings are displayed in the table of results.

Discussion

In line with previous studies (15), our survey highlighted a general satisfaction of mental health providers for telematic assistance, even though the face-to-

Table 1. Results from the ad-hoc survey questionnaire

	Psychiatrists (N=66)	**Psychoterapist** (N=49)	**Psychologists** (N=104)	Chi²/ ANOVA	p
Type of assistance					
Public Health System	23 (34.8)	21 (42.9)	34 (32.7)	16.086	<.001
Private sector	22 (33.3)	12 (24.5)	55 (52.9)		
Both of them	21 (31.8)	16 (32.7)	15 (14.4)		
Video-assistance availability at workplace					
Yes	366 (54.5)	34 (69.4)	96 (92.3)	47.012	<.001
No, only phone assistance	22 (33.3)	4 (8.2)	3 (2.9)		
Only in private sector	8 (12.2)	11 (22.4)	5 (4.8)		
Starting assistance online					
Yes	16 (24.2)	25 (51.0)	60 (57.7)	18.791	<.001
No	50 (75.8)	24 (49.0)	44 (42.3)		
Percentage of patients who accepted the video-assistance					
< 21%	21 (31.8)	14 (28.6)	12 (11.5)	11.992	.017
21-80%	27 (40.9)	20 (40.8)	57 (54.8)		
> 80%	18 (27.3)	15 (30.6)	35 (33.7)		
Patients who accepted video-assistance after initial refuse					
All	12 (18.2)	9 (18.4)	13 (12.5)	8.160	.086
More than 50%	43 (65.2)	22 (44.9)	66 (63.5)		
Less than 50%	11 (16.6)	18 (36.7)	25 (24.0)		
Patients' reactions to video-assistance					
1. Embarassment	16 (24.2)	17 (34.7)	19 (18.3)	4.975	.083
2. More spontaneity	12 (18.2)	10 (20.4)	21 (20.2)	.127	.938
3. Disinibition	4 (6.1)	8 (16.3)	10 (9.6)	3.320	.190
4. Solitude	9 (13.6)	7 (14.3)	6 (5.8)	4.021	.124
5. Loss of cooperation	7 (10.6)	10 (20.4)	10 (9.6)	3.849	.146
6. Less professionality	14 (21.2)	7 (14.3)	8 (7.7)	6.484	.039
7. Better thinking ability	1 (1.5)	4 (8.2)	6 (5.8)	2.837	.242
8. Consolation from continuity of care	27 (40.9)	29 (59.2)	67 (64.4)	9.301	.010
9. Intrusion of therapist in every-day life	2 (3.0)	4 (8.2)	5 (4.8)	1.572	.456
10. Pleasant proximity of therapist to every-day life	13 (19.7)	13 (26.5)	25 (24.0)	.798	.671
11. Less privacy of session	23 (34.8)	22 (44.9)	45 (43.3)	1.560	.458
12. Altered perception of the time of the session	10 (15.2)	11 (22.4)	17 (16.3)	1.184	.553
13. Suspect of scarce attention of the therapist	4 (6.1)	7 (14.3)	8 (7.7)	2.643	.267
14. Desire to restore previous condition	31 (47.0)	25 (51.0)	38 (36.5)	3.483	.175
15. Other	2 (3.0)	2 (4.1)	6 (5.8)	.729	.695
Therapists' reactions to video-assistance					
1. Embarassment	2 (3.0)	6 (12.2)	2 (1.9)	8.655	.013
2. Scarce mimic contact	23 (34.8)	19 (38.8)	23 (22.1)	5.638	.060
3. Better attention	6 (9.1)	6 (12.2)	9 (8.7)	.522	.770
4. Difficulty of concentration	17 (25.8)	21 (42.9)	19 (18.3)	10.462	.005
5. Intrusion by patients in everyday-life	10 (15.2)	10 (20.4)	23 (22.1)	1.265	.531
6. Less privacy of session	12 (18.2)	11 (22.4)	23 (22.1)	.456	.796
7. Altered perception of the time of the session	14 (21.2)	9 (18.4)	26 (25.0)	.917	.632
8. Consolation from feeling professionaly useful	19 (28.8)	21 (42.9)	52 (50.0)	7.476	.024
9. Diversion from personal fears	3 (4.5)	2 (4.1)	5 (4.8)	.040	.980

Table 1. Results from the ad-hoc survey questionnaire

	Psychiatrists (N=66)	**Psychoterapist** (N=49)	**Psychologists** (N=104)	Chi²/ ANOVA	p
10. Consolation from care continuity	33 (50.0)	30 (61.2)	70 (67.3)	5.078	.079
11. Scarce clinical control	29 (43.9)	15 (30.6)	25 (24.0)	7.433	.024
12. Better thinking ability	0 (0.0)	4 (8.2)	7 (6.7)	5.139	.077
13. Meeting patients in their everyday life led to better comprehension	12 (18.2)	11 (22.4)	25 (24.0)	.820	.664
14. Meeting patients in their everyday life obstaculated the possibility of freely imagine their interior world	3 (4.5)	6 (12.2)	2 (1.9)	7.484	.024
15. Other	2 (3.0)	4 (8.2)	7 (6.7)	1.551	.460
Satisfaction about video-assistance					
Completely satisfied	28 (42.4)	32 (65.3)	77 (74.0)	21.835	<.001
Partly satisfied	35 (53.0)	13 (26.5)	26 (25.0)		
Not satisfied	3 (4.6)	4 (8.2)	1 (1.0)		
Difficulty to be paid (for private workers only)					
No	44 (66.7)	39 (79.6)	85 (81.7)	8.355	.079
Yes, for online payments	19 (28.8)	6 (12.2)	15 (14.4)		
Yes, for requests of discount	3 (4.5)	4 (8.2)	4 (3.9)		
Patients' interest for therapist's health					
Often	25 (37.9)	20 (40.8)	17 (16.3)	18.231	.001
Sometimes	33 (50.0)	19 (38.8)	54 (51.9)		
Never	8 (12.1)	10 (20.4)	33 (31.7)		
Request of reassurance about pandemic					
Often	42 (63.6)	18 (36.7)	27 (26.0)	24.909	<.001
Sometimes	18 (27.3)	20 (40.8)	55 (52.9)		
Never	6 (9.1)	11 (22.4)	22 (21.2)		
Feeling of impotence					
Often	14 (21.2)	9 (18.4)	8 (7.7)	8.567	.073
Sometimes	41 (62.1)	27 (55.1)	68 (65.4)		
Never	11 (16.7)	13 (26.5)	28 (26.9)		
Availability to use video-assistance in the future					
Yes	19 (28.8)	18 (36.7)	47 (45.2)	16.873	.002
No	5 (7.6)	8 (16.3)	1 (1.0)		
Yes, but only in particular circumstances	42 (63.6)	23 (47.0)	56 (53.8)		
Patients' opposition to face-to-face session because of fear of contagion	3.11 ± 1.08	3.20 ± 1.06	2.75 ± 1.14	3.650	.028
Patients' resistance to setting changes	2.58 ± 0.90	2.67 ± 1.11	2.61 ± 0.95	.146	.864
Extra-session contacts	2.61 ± 1.19	2.00 ± 1.08	1.81 ± 1.05	10.829	<.001*

face approach remains preferred in a non-emergency condition (16). Our findings suggest that the main factors influencing the attitude of mental health providers toward video-assistance are the "physical setting conditions" (e.g., electronical devices and a proper intimate space in the workplace) and the "mental setting" (e.g., modality of therapy, psychopharmacological vs psychotherapeutic assistance, theoretical approach).

Regarding to the "physical setting", we highlighted that scarce availability of video call assistance service was more likely reported by mental health providers employed in the public health system, frequently obliged to simple phone contacts limiting the mimic expressivity of patients. At the same time, some freelance mental health providers, forced during lockdown to work from home, mainly complained about the lack of privacy, as well as difficulties in concentration and an impaired perception of the session time. An adequate private space seemed to be crucial to guarantee privacy and intimacy for both therapists and patients

and to preserve the neutrality of the therapist in patient's mind (17-19).

Regarding the "mental setting", psychiatrists and psychotherapists presented a stronger resistance to the use of the video call assistance service, may be due to more rigid setting rules, their theoretical training and of the typology of patients treated. On the contrary, psychologists in psychotherapy training, probably because of the younger age and a less rigid mental assessment, were those more enthusiastic with the telematic assistance service.

A general upset emerged among psychiatrists, who expressed the fear of a scarce clinical monitoring, especially for acute patients who need an integrated care model also involving nurses, rehabilitators, educators. It can also be argued that a more rigid medical setting would be required for patients under psychopharmacological treatment, to better monitor drug adverse reactions (e.g., soft neurological signs, akathisia, rigidity, psychomotor activation, or retardation) through an accurate in presence objective examination (15).

As far as concerning the psychotherapeutic contest, we investigated how two aspects related to the new online approach affected the ability of "imagining together" in the therapeutic room: 1) the introduction of some concrete elements in the therapeutic setting; 2) on the contrary, the need of a "symbolic jump", determined by the physical absence of both mental health providers and patients. Some mental health providers reported how a concrete approach to details of their patients' everyday life provided them a more realistic and accurate clinical picture, while, only a few of them, felt their ability of imagining their patients' world weakened by the intrusion of concrete elements (10).

In line with findings from similar research (20), therapeutic alliance, as well as the emotional connectedness with the patient during online sessions, were not evaluated poorer compared to the face-to-face condition, with some therapists noticing that some patients were even more talkative and spontaneous. Psychiatrists and some psychotherapists, probably because of their medical training and their commitment in hospital facilities, noticed a particular concern from patients about their health condition and a stronger tendency to violate the therapy rules (e.g., extra-session contacts).

The majority of the patients expressed to their therapists mild to good degree of satisfaction with the online therapy, although a general wish to go back to the previous face to face condition was reported. It is also possible to argue that specific categories of patients (e.g., those with post-traumatic stress disorder - PTSD) could experience the physical distance of the therapist as protective from emotional instability or, on the contrary, facilitating dissociation (21-23).

The possibility to include the session time in a routine scheme could be very important for patients, for pragmatic (e.g., an occasion of sociality) and symbolic (rituality of the setting) reasons and this aspect can be totally lost in a telematic approach (24). At the same time, the conception of the setting as a "safe neutral sanctuary" for the patients is aleatory, as a completely standardized setting is far from being realizable. Moreover, continue setting deviations are not only possible but even necessary, as the setting is a dynamic process, in which real, personal, and unique characteristics of patients and therapists meet (25).

Limitations

This study needs to be interpreted in the light of several limitations. The main limitation of this survey is the small sample size of mental health providers across only one city with a low ORR that limited the generalizability of the results. With regard to methodology, the cross-sectional study design did not allow an evaluation of the perceived efficacy of online therapy over the time and a non-validated instrument conceptualized for emergency purpose was used. Moreover, patients' reactions to transition to the online therapy were only indirectly inferred, through the investigation of their therapists' opinions about.

Conclusions

To the best of our knowledge (26), this is the first original study in Italy that investigates reactions of mental health providers to the new therapeutic setting and hypothesizes how this experience will modify the assistance of psychiatric patients in the near future.

COVID-19 pandemic creates an opportunity to overcome normative, technological, and cultural barriers to the use of online psychotherapy, showing the importance of adapting the therapeutic setting to both collective and individual needs. As reported by our survey, despite initial concerns about its effectiveness and efficacy, a general degree of satisfaction was expressed by the majority of the mental health providers, as video-assistance assured care continuity. Moreover, our research experience highlighted how teleassistance could facilitate the continuity of care especially for vulnerable subgroups of patients (e.g. those dislocated in suburban areas or affected by mental illnesses that limit perceptions of changes in the external environment, thus negatively impacting on therapeutic adherence) even outside the pandemic contest.

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APPENDIX

COVID-19 E VARIAZIONI DEL SETTING TERAPEUTICO: QUESTIONARIO PER GLI OPERATORI DELLA SALUTE MENTALE

1. Indica la tua qualifica professionale:
- □ Psicologo
- □ Psicoterapeuta
- □ Psichiatra

2. Indica il tuo luogo di lavoro:
- □ Servizio Pubblico
- □ Studio professionale privato
- □ Entrambi

3. Il tuo Servizio o il tuo studio ti dà la possibilità di seguire i pazienti tramite videochiamate?
- □ Si
- □ No, il contatto avviene solo per telefono
- □ No nel Servizio Pubblico ma sì nell'attività privata

4. Ti è capitato in questo periodo di iniziare una relazione terapeutica online con un paziente mai incontrato personalmente?
- □ Si
- □ No

5. Hai notato nei pazienti una resistenza a questo cambiamento di approccio?

Pochissimo	1	2	3	4	5	Moltissimo

6. Indicativamente, quale percentuale dei tuoi pazienti ha accettato la consulenza online?
- □ 0-20%
- □ 21-80%
- □ >80%

7. Hai notato una resistenza a recarsi al Servizio/studio per paura del contagio?

Pochissimo	1	2	3	4	5	Moltissimo

8. Pazienti inizialmente oppositivi alla consulenza online, hanno poi cambiato idea?
- □ Tutti
- □ Alcuni
- □ Nessuno

9. Nei colloqui telematici hai l'impressione che l'assenza fisica dell'operatore induca nel paziente reazioni di (puoi selezionare più di un'opzione):
- □ Imbarazzo
- □ Maggiore spontaneità
- □ Disinibizione
- □ Solitudine

- □ Perdita di collaborazione
- □ Percezione da parte del paziente di una minore professionalità del contatto
- □ Maggiore facilità di associazioni
- □ Sensazione di consolazione/accoglienza derivante dalla possibilità di continuare il rapporto terapeutico
- □ Sensazione di minore riservatezza del contatto (ad es. per presenza conviventi, mancanza di spazi adeguati)
- □ Piacevole sensazione di vicinanza dell'operatore alla vita quotidiana o agli ambienti del paziente
- □ Sensazione di minore riservatezza del contatto (ad es. per presenza conviventi, mancanza di spazi adeguati)
- □ Alterata percezione del tempo della seduta (in eccesso o in difetto)
- □ Sospetto di scarsa attenzione dell'operatore
- □ Desiderio di tornare alla condizione precedente
- □ Altro:

10. Nei colloqui telematici hai l'impressione che l'assenza fisica del paziente induca nell'operatore reazioni di:

- □ Imbarazzo
- □ Difficoltà di comunicazione mimica
- □ Attenzione migliorata
- □ Difficoltà di concentrazione
- □ Percezione di un aspetto intrusivo nel quotidiano (es. se l'operatore lavora da casa)
- □ Alterata percezione del tempo della seduta (in eccesso o in difetto)
- □ Sensazione di minore riservatezza del contatto (ad es. per presenza conviventi, mancanza di spazi adeguati)
- □ Sensazione di consolazione derivante dalla possibilità di continuare l'attività lavorativa e di sentirsi utile in un momento collettivamente difficile
- □ Distrazione da angosce personali
- □ Possibilità di portare avanti il rapporto terapeutico
- □ Timore che il controllo della situazione clinica non sia sufficiente
- □ Maggiore facilità di associazioni nel terapeuta
- □ Il mondo del paziente acquisisce una concretezza che può aiutare la comprensione e gestione di alcuni aspetti clinici
- □ Il mondo del paziente acquisisce una concretezza che ostacola la capacità immaginativa del terapeuta
- □ Altro

11. Ti sembra di essere riuscito a mantenere una continuità nel setting terapeutico?

Pochissimo	1	2	3	4	5	Moltissimo

12. Ti sembra che questa modalità di incontro terapeutico induca il paziente a sentirsi più elicitato a cercare un contatto con il terapeuta al di fuori dell'orario di visita prestabilito?

Pochissimo	1	2	3	4	5	Moltissimo

13. Nell'ambito privato sono insorte difficoltàà nella retribuzione dell'onorario?

- □ No, nessuna
- □ Sì, alcuni pazienti non gradiscono tecniche di pagamento online
- □ Sì, alcuni pazienti hanno richiesto uno sconto per le prestazioni online
- □ Altro

14. In questa situazione di pandemia e di pericolo per i sanitari, hai notato un interessamento da parte dei pazienti, tramite telefonate o messaggi, al tuo stato di salute?

- □ Spesso
- □ Talvolta
- □ Mai

15. Ti capita che i pazienti ti chiedano consigli/rassicurazioni relativamente alla situazione di pandemia?
□ Spesso
□ Talvolta
□ Mai

16. In questo particolare momento, ti è capitato di sentirti professionalmente impotente?
□ Spesso
□ Talvolta
□ Mai

17. Ricorreresti a questa modalitàà di contatto terapeutico anche in futuro?
□ Si
□ No
□ Si, ma solo in particolari condizioni